ATTACHMENT 5

PRIOR AUTHORIZATION CHILD/ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA)

COMPLETION INSTRUCTIONS

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The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

GENERAL INSTRUCTIONS

The information contained on this prior authorization child/adolescent day treatment attachment (PA/CADTA) will be used to make a decision about the amount of child/adolescent day treatment which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible. Where noted in these instructions, you may attach material which you may have in your records.

Initial prior authorization request: Please complete the PA/RF and the entire PA/CADTA and attach all required materials. Please label all attachments (e.g., "Day Treatment-Treatment Plan"). The initial authorization will be for a period of no longer than three months.

First reauthorization: Please complete the PA/RF and page 1 of the PA/CADTA. Attach a copy of the HealthCheck referral form which was included with the initial authorization request. Attach a summary of the treatment to date, and a revised day treatment services treatment plan. Note progress on short- and long-term goals from the original plan. Be explicit in your summary as to the need for continued day treatment services. Authorization will be for a period of no longer than three months.

Second reauthorization: Please complete the PA/RF and page 1 of the PA/CADTA. Attach a copy of the HealthCheck referral form, which was included with the initial authorization request. There should also be an updated multi-agency treatment plan and an updated screening (Achenbach or CAFAS) using the same screening tool used for the initial request. Summarize the treatment since the previous authorization. The need for continued day treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of day treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Authorization will be for a period of no longer than three months.

Subsequent reauthorizations: Please complete the PA/RF and page 1 of the PA/CADTA. Attach a copy of the HealthCheck referral form which was included with the initial authorization request. Attach a summary of the treatment since the previous authorization. Address why recipient has not made transition to aftercare services. Strong justification will be required for day treatment services exceeding nine months per episode of treatment.

Please check the appropriate box at the top of the PA/CADTA to indicate whether this request is an initial, first reauthorization, second reauthorization or subsequent request. Make sure that the appropriate materials are included for the type of request indicated.

Multiple services. When a recipient will require prior authorization for other services concurrent to the day treatment (e.g., in-home treatment), a separate PA/RF must be submitted for those services and the appropriate prior authorization attachment and all required materials must be submitted for that other service. Please indicate on this prior authorization request that services will be coordinated with the other service provider (if the service will be provided by a different agency). These other services must be identified on the multi-agency treatment plan.

SECTION I.

RECIPIENT INFORMATION

Elements 1-4. Enter the recipient's last name, first name, middle initial, and 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

Element 5. RECIPIENT'S AGE
Enter the age of the recipient in numerical form (e.g., 21,45,60, etc.).

PROVIDER INFORMATION

Element 6. CERTIFIED DAY TREATMENT PROVIDER NAME
Enter the name of the Medical Assistance certified day treatment program which will be billing for the services.

Element 7. DAY TREATMENT MA PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number for the day treatment provider. Providers will be assigned a unique provider number for the child/adolescent day treatment program.

Element 8. NAME AND PHONE NUMBER OF CONTACT PERSON
Enter the name and phone number (including area code) of a person who would be able to answer questions about this request.

Element 9. Indicate the date for which you wish services to be first authorized and the end date for the authorization period. See the general instructions for information on the length of authorization that will be generally allowed. If the start date is prior to when this request will be received at EDS, clinical rationale must be provided justifying the need to start treatment prior to getting authorization. Requests may be backdated up to 10 working days on the initial authorization if this is requested and appropriate rationale is provided.

Element 10. Indicate the total number of hours for which you are requesting MA reimbursement for this PA grant period.

SECTION II.

A. Present or attach a summary of the psychiatric assessment and differential diagnosis. Diagnoses on all five axes of the DSM-III-R are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. If not conducted by a psychiatrist, a psychiatrist must review and sign the summary and diagnosis. In cases where the only, or primary, diagnosis is a conduct disorder, the request should provide sufficient justification for the appropriateness of day treatment. In those cases where the only, or primary, diagnosis is a psychoactive substance abuse disorder, requests will generally not be approved unless there is sufficient justification for the appropriateness of a mental health day treatment program. Providers may attach copies of an existing assessment if it is no longer than two pages.

B. Present or attach a summary of the recipient's illness/treatment/medication history. For individuals with significant substance abuse problems, the multi-agency treatment plan should indicate how theses will be addressed. Providers may attach copies of illness/treatment/medication histories that are contained in their records if they do not exceed two pages.

C. Complete the checklist for determining than an individual meets the criteria for severe emotional disturbance. The following information defines the allowable conditions for parts 2 and 3 of the checklist:

For part 2 the individual must have one of the following DSM-III-R diagnoses:

Adult diagnostic categories appropriate for children and adolescents are:

organic mental syndromes and disorders (292.00* - 292.90*, 294.80)
psychoactive substance use disorders (303.90, 304.00 - 304.90*, 305.00, 305.20* - 305.90*) (use codes for *abuse only*)
schizophrenia (295.1x, 295.2x, 295.3x, 295.6x, 295.9x)
schizoaffective disorders (295.70)
mood disorders (296.2x - 296.70, 300.40, 301.13, 311.00)
somatoform disorders (300.11, 300.70*, 300.81, 307.80)
dissociative disorders (300.12 - 300.15, 300.60)
sexual disorders (302.20 - 302.40, 302.70 - 302.79, 302.81 - 302.84, 302.89, 302.90, 306.51)
intermittent explosive disorder (312.34)
pyromania (312.33)
adjustment disorder (309.00, 309.23 - 309.90)
personality disorders (coded on Axis II: 301.00, 301.20 - 301.50, 301.60 - 301.90)
psychological factors affecting physical condition (316.00 - *and specify physical condition on Axis III)*

Disorders usually first evident in infancy, childhood and adolescence include:

pervasive developmental disorders (coded on Axis II: 299.00, 299.80)
disruptive behavior disorders (312.00, 312.20, 312.90, 313.81, 314.01)
anxiety disorders of childhood or adolescence (309.21, 313.00, 313.21)
eating disorders (307.10, 307.50, 307.51, 307.52, 307.53)
gender identity disorders (302.50, 302.60, 302.85*)
tic disorders (307.20 - 307.23)
reactive attachment disorder of infancy or early childhood (313.89)

For part 3 the symptoms and impairments are defined as follows:

SYMPTOMS

1) Psychotic symptoms - serious mental illness (e.g. schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.

2) Suicidality - The individual must have made one attempt within the last three months or have significant ideation about or have a plan for suicide within the past month.

3) Violence - The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

FUNCTIONAL IMPAIRMENT (compared with expected developmental level):

1) Functioning in self care - Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

2) Functioning in community - Impairment in community function is manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which results in potential involvement or involvement the juvenile justice system.

3) Functioning in social relationships - Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

4) Functioning in the family - Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others, e.g.- fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent.

5) Functioning at school/work - impairment in any *one* of the following:

   a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame - e.g. consistently failing grades, repeated truancy, expulsion, property damage or violence toward others; **or**

   b) meeting the definition of "child with exceptional educational needs" under ch. PI 11 and 115.76(3) Wis. Stats.;**or**

   c) Impairment at work is the inability to be consistently employed at a self- sustaining level - e.g. inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job.

D. Describe the treatment program which will be provided. Participation in specific groups/activities must be justified by the treatment plan. Attach a summary/description of groups or program components. The

information presented should be adequate for determining that those services for which reimbursement is requested are MA reimbursable (as noted in Section III-D).

E. If not previously addressed, indicate the rationale for day treatment as opposed to other treatment modalities. Where less intensive outpatient (clinic) services have not been provided, discuss why not. Providers should present this justification in their own words and not assume that the consultants can infer this from other materials presented with the request.

F. Indicate the expected duration of day treatment. Describe services expected to be rendered following completion of day treatment and transition plans. While providers are expected to indicate their expectations on the initial request, is critical that plans for terminating day treatment be discussed in any requests for services at and beyond six months of treatment.

SECTION III

The following materials must be attached and labeled:

A. The prior authorization request form (PA/RF) may be obtained from EDS. The words "**HealthCheck Other Services**" should be written across the top of the form in red ink. Enter procedure code W7081 in element 14 and "Child/Adolescent Day Treatment" in element 18.

B. A HealthCheck referral must accompany the request. When the request is for a reauthorization the provider should attach a copy of the initial HealthCheck referral. The initial request for this recipient must be received by EDS within six months of the date of the HealthCheck referral.

C. The multi-agency treatment plan must be developed by representatives from all systems involved with the recipient (school, juvenile justice, social services, etc.). The plan must address the role of each system in the overall treatment and the major goals for each agency involved. Ideally, the plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning, the provider must document the reason and what attempts were made to include them. The plan should indicate why day treatment services are necessary and desirable. The individual who is coordinating the multi-agency planning should be clearly identified. A psychiatrist must sign either the multi-agency or day treatment plan (please make sure the physician is identified as a psychiatrist). A model multi-agency treatment plan may be obtained by writing to the SED coordinator at:

SED Coordinator
Division of Community Services
Office of Mental Health
P.O. Box 7851
Madison, WI 53707-7851

(608) 266-6838; Fax: (608) 266-0036

If a plan other than the model plan is used, all the information on the model must be included.

D. The treatment team must complete a treatment plan covering their day treatment services. The plan must contain measurable goals, specific methods, and an expected timeframe for achievement of the goals. The treatment plan must be tailored for the individual recipient.

   The plan must clearly identify how specific program components relate to specific treatment goals. The methods allow for a clear determination that the services provided meet criteria for Medical Assistance covered services. Services which are primarily social or recreational in nature, educational services, and mealtimes are not reimbursable.

E. Providers must complete and attach the results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale. Additional information about these screening instruments can be obtained from the SED Coordinator at the address noted above.

F. Submit a copy of an AODA assessment where the psychiatric assessment indicates significant AODA problems and AODA related services will be part of the day treatment program. The assessment may be summarized in Section II- A or- B as part of the psychiatric assessment or illness history. If the AODA problems will be addressed by some other agency, this should be indicated in the multi-agency treatment plan.

   The request must be signed and dated by the day treatment program director.